2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the Medicaid services were provided or to another instate location that is acceptable to the division or its authorized agent. The provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform the field audit in any out-of-state location, if the location is acceptable to the Division.

(E) Change in Provider Status.

1. Upon termination of participation in the Medicaid program or change of ownership, the provider is required to submit a cost report for the period ending with the date of termination or change, regardless of its tax period. The fully completed cost report with all required attachments and documentation is due within forty-five (45) days after the date of termination or change.

2. If a cost report is more than ten (10) days past due, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the pediatric nursing care facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that owns, controls or manages one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Allocation of central office or pooled costs to individual facilities shall be consistent from year-to-year. If a desk review or field audit establishes that records are not maintained so as to clearly identify information required by this rule, none of the commingled cost shall be recognized as allowable cost in determining the facility's Medicaid per-diem rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

3. Certain home office or related management company costs that would otherwise be reported in the patient care component of the cost reported in the patient care component of the cost report if the facility performed the services or purchased the services independently may be reported in the patient care cost category, if services were actually rendered at the individual facility. Allocation of these costs must be based on the hours worked on-site in an individual facility. Direct patient service cost not meeting these requirements shall be reported in the general and administrative cost category.

(11) Rate Determination.

(A) Except as provided in subsection (11)(B), and subject to the timely filing provisions of section (10), a facility's per-diem rate shall be determined on July 1 of each state fiscal year, beginning July 1, 1989 or the qualification date, whichever is later, based upon the data contained in the desk-reviewed or field-audited second prior year cost report,or both; provided, the reported costs are allowable, covered, properly apportioned, properly allocated and properly classified as prescribed elsewhere in this rule. A facility's per-diem rate shall be the sum of the patient care per-diem rate, the general and administrative per-diem rate and the capital per-diem rate. Applicable trend factors shall be applied only to the patient care component of the per-diem rate. Applicable trend factors as used in this section are the trend factors that were authorized subsequent to the last day of the facility fiscal year covered by the second prior year cost report, up to and including the trend factor adjustment which may be authorized on July 1 when the annual rate is determined. Procedures for determination of the per-diem rates in each cost category are as follows:

1. Patient care. From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate patient care costs from lines forty-five through sixty (45--60), and sixty-two through seventy-five (62-- 75), seventy-seven through eighty-five (77--85), eighty-seven through ninety-five (87--95), ninety-seven through one hundred three (97--103), line one hundred five (105) and lines one hundred thirteen (113)

through one hundred twenty (120). The accumulated patient care costs will be divided by the patient days for the reporting period identified from line eight (8), item six (6), column eight (8). The result of this procedure will be the Patient Care Per-Diem Rate;

2. General and administrative. From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate general and administrative costs from line one hundred nine (109), line one hundred eleven (111), line one hundred twelve (112) and lines one hundred twenty-two through one hundred fifty (122--150). The accumulated general and administrative costs will be divided by the greater of patient days for the reporting period from line eight (8), item six (6), column eight (8) or ninety percent (90%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The General and Administrative Per-Diem Rate shall be the lesser of:

A. The results of the procedure described in paragraph (11)(A)2.; or

B. Fifteen percent (15%) times the results of the procedure described in paragraph (11)(A)1.; and

3. Capital.

A. For LTC facilities which were certified for participation in the Medicaid program at any time prior to June 30, 1989,

and with valid participation agreements in effect on June 30, 1989, and which satisfy all the qualifications necessary for participation in the pediatric nursing care program described in this rule, the per-diem rate for capital under this rule shall be the sum of lines one hundred and six (106), one hundred seven (107), one hundred eight (108) and one hundred ten (110) from the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, divided by the greater of patient days for the reporting period from line eight (8), item six (6), column (8) or ninety-three percent (93%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13).

B. For new facilities, the per-diem rate for capital shall be the sum of the building, building equipment and moveable equipment rate, plus the land rate, plus the working capital rate determined in accordance with the following procedures. The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13).

(I) The building, building equipment and moveable equipment rate will be computed as follows:

(a) Determine the lesser of--

I. Actual acquisition cost, which is the original owner's cost to construct or acquire the building including moveable equipment but excluding land costs; or

II. Reasonable construction or acquisition cost computed by applying the Dodge Calculator as defined in subsection (4)(I) of this rule for the city, St. Louis, Kansas City or Columbia, geographically closest to the facility, multiplied by one hundred eight percent (108%) as an allowance for fees authorized as architectural or legal not included in the Dodge Calculator, multiplied by the square footage of the facility not to exceed three hundred twenty-five (325) square feet per bed plus an allowance of one thousand five hundred dollars ($1500) per bed for moveable equipment;

(b) Multiply by a return rate of twelve percent (12%); and

(c) Divide by ninety-three percent (93%) of the facility's total available beds times three hundred sixty-five (365) days.

(II) The land rate is computed as follows:

(a) The maximum allowable land area is defined as five (5) acres for a facility with one hundred (100) or fewer beds and one (1) additional acre for each additional one hundred (100) beds or fraction of beds for a facility with one hundred one (101) or more beds; and

(b) Calculation.

I. For facilities with land areas at or below the maximum allowable land area, multiply the acquisition cost of the land by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds times three hundred sixty-five (365) days.

II. For facilities with land areas greater than the maximum allowable land area, divide the acquisition cost of the land by the total acres, multiply by the maximum allowable land areas, multiply by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds times three hundred sixty-five (365) days.

III. The working capital rate will be twenty cents (20¢) per day. This amount was determined to be the average daily balance due to a facility for services provided to the state with a return rate of twelve percent (12%), divided by ninety-three percent (93%).

IV. If a provider does not provide documentation in support of actual acquisition cost necessary to determine the per-diem rate for capital, the sum of the building, building equipment and moveable equipment rate, the land rate and working capital rate will be established as a per-diem rate of six dollars ($6).

(B) New Facilities.

1. Initial per-diem rates. A new facility shall submit to the division a written request for establishment of an initial per-diem rate. The request shall include all documentation necessary to determine the allowable capital in accordance with procedures described in subparagraph (11)(A)3.B. The initial per-diem rate shall become effective on the date the new facility satisfies all licensing and certification requirements of the Division of Aging for participation in the Medicaid program as an SNF and any additional requirements of this rule for participation in the pediatric nursing care program. The initial per-diem rate shall be established as the lower of the level-of-care ceiling in effect on the effective date of the initial per-diem rate or the average private pay rate, or the Medicare (Title XVIII) per-diem rate, if applicable.

2. Interim rate. The new facility shall file a cost report in accordance with all applicable requirements of this regulation by the first day of the fourth month following the close of the new facility's first full facility fiscal year. Based upon the data contained in the desk-reviewed or field-audited first full facility fiscal year cost report, or both; provided, the reported costs are allowable, covered, properly apportioned, properly allocated and properly classified as prescribed elsewhere in this rule, an interim per-diem rate shall be established. The interim per-diem rate shall be the sum of the patient care per-diem rate and the general and administrative per-diem rate, applying the procedures described in paragraphs (11)(A)1. and 2., plus the capital per-diem rate as originally fixed per subparagraph (11)(A)3.B. The interim rate shall

be established retroactive to the first day of the first full facility fiscal year and prospectively up to the July 1 following the last day of the facility's second full facility fiscal year. On the July 1 following the last day of the facility's second full facility fiscal year, the facility will become eligible for the annual rate determination described in subsection (11)(A). New facilities are eligible for trend factors applied only to the patient care portion of the per-diem rate which may be authorized between the effective date of the interim rate and the date the facility becomes eligible for annual rate determination.

(12) Rate Reconsideration.

(A) A provider may request reconsideration of the per-diem rate only under the following circumstances:

1. When the provider can show that it incurred higher costs due to circumstances beyond its control and the circumstances are not experienced by the nursing home industry in general, the request must have a substantial cost effect. These circumstances include, but are not limited to:

A. Acts of nature, such as fire, earthquakes and flood, that are not covered by insurance;

B. Vandalism, civil disorder, or both; or

C. Replacement of capital depreciable items not built into the existing rate that are the result of circumstances not related to normal wear and tear or upgrading of existing systems;

2. The request for rate reconsideration must be submitted in writing to the Division, must specifically and clearly identify the reason for the request, must include sufficient documentation evidencing that the costs were actually incurred, must be in detail sufficient for the division to determine whether or not the costs were or were not included in the rate, and must include the amount requested;

3. The Division will make a recommendation to the director of the Department of Social Services within sixty (60) days following the receipt of all documentation required or necessary, or both, to evaluate the request. The director's or his / her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the Division's recommendation; and

4. The director's or his / her designee's final determination on the Division's recommendation shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective on the first day of the following month.

(13) Rate Adjustments.

(A) Unless specifically provided elsewhere in these rules, the division may increase or decrease the per-diem rate both prospectively and retrospectively only under the following conditions:

1. Pursuant to a court decision; or

2. Pursuant to an Administrative Hearing Commission decision or order.

(B) Unless specifically provided elsewhere in these regulations, the Division may decrease the per-diem reimbursement rate both prospectively and retrospectively only under the following conditions:

1. If the information contained in or attached to a cost report on which a per-diem rate has been based is found to be fraudulent, misrepresented or inaccurate, and if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher per-diem rate than the facility would have received in the absence of such information;

2. When the facility's Medicaid per-diem rate is higher than either its private pay rate or its Medicare (Title XVIII) rate; or

3. When a determination through desk audits, field audits and other means established that unallowable costs were included in a cost report used to establish the per-diem rate.

(C) Global Per-Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per-diem rate adjustments. Global per-diem rate adjustments shall be added to the level of care ceiling.

1. Minimum wage adjustment. Effective for payment dates on or after November 15, 1996, an increase of two dollars and forty-five cents ($2.45) shall be granted to a facility's per diem to allow for the change in federal minimum wage. Utilizing fiscal year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty cent ($.50) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the Director of Nursing, the Administrator and Assistant Administrator.

(14) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this regulation, the Division may also impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the Division in accordance with State Regulation 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(15) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may appeal final decisions of the director, Department of Social Services or the Division of Medical Services to the Administrative Hearing Commission.

(16) Transition. Cost reports used for rate determination shall be adjusted by the Division in accordance with the applicable cost principles provided in this rule for those facilities with Medicaid participation agreements in effect on June 30, 1989, which also qualify on July 1, 1990, for participation in the pediatric nursing care program.

APPENDIX A

ABD Pads
A & D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses
Air P.R. Mattresses
Airway--Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Alternating Pressure Pads
Antacids, Nonlegend
Applicators, Cotton-Tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages (elastic or cohesive)
Bandaids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans (all types)
Beds, Manual, Electric, Clinitron
Bedside Tissues

Benzoin
Betadine
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes (all types)
Cannula--Nasal
Catheter Indwelling
Catheter Plugs
Catheter Trays
Catheter (any size)
Colostomy Bags
Combs
Commodes (all types)
Composite Pads
Cotton Balls
Crutches (all types)
Decubitus Ulcer Pads/Dressings
Denture Cleaner/Soak
Denture Cups
Deodorants
Diapers
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes

Dressing Tray
Dressings (all types)
Drugs, Stock (excluding Insulin)
Enema Soap
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail Clipping and Cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads, Turning Frames, or both
Foot Cradle (all types)
Gastric Feeding Unit, (including bags)
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hairbrushes
Hair Care, Basic
Hand-Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket
Ice Bags
Incontinency Care

Incontinency Pads and Pants
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral
Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
I.V. Tubing
Jelly--Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap and Oil
Massages (by facility personnel)
Mattresses (all types)
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Aerosol
Mouthwashes
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and Feeding Bags
Nebulizer and Replacement Kit
Needles (hypodermic, scalp, vein)
Needles (various sizes)
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care

Nursing Supplies and Dressing
Ostomy Supplies (adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings skin barriers, tail closures)
Overhead Trapeze Equipment
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Peroxide
Pitcher
Plastic Bib
Pump (aspiration and suction)
Pumps for Alternating Pressure Pads
Respiratory Equipment (Ambu Bags, cannulas, compressors, humidifiers, IPPB Machines and circuits, mouth pieces, nebulizers, suction catheters, suction pumps, tubing)
Restraints
Room and Board (semiprivate or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Shampoo
Shaves
Shaving Cream
Sheepskin
Side Rails
Soap

Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Sterile Saline for Irrigation
Sterile Water for Irrigation
Stomach Tubes
Stool Softeners, Nonlegend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, Disposable
Tape (for laboratory tests)
Tape (nonallergic or butterfly)
Testing Sets and Refills (S & A)
Therapy Services
Toenail Clipping and Cleaning
Tongue Depressors
Toothbrushes
Toothpaste

Tracheostomy Sponges
Trapeze Bars
Tray Service
Underpads
Urinals, Male and Female
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Nonlegend
Walkers (all types)
Water Circulating Pads
Water Pitchers
Wheelchairs (amputee, geriatric, heavy duty, hemi, lightweight, one-arm drive, reclining, rollabout, semireclining, standard)

APPENDIX B

Noncovered Supplies, Items and Services

Audiology Services
Barber and Beauty Shop Services
Cigarettes, Cigars, Pipes and Tobacco
Clothing
Cosmetics
Dental Services
Dry Cleaning
Eye Examinations
Eye Glasses
Hearing Aids
Home Parenteral Nutrition/Total Parenteral Nutrition Solutions, Additives, Supplies
Hospital Services
Laboratory Services
Optical Services
Orthotic Devices
Pharmacy
Physician
Podiatry Services
Prosthetic Devices
Ventilators
Wheelchair Batteries
Wheelchairs, Customized (chairs that are fitted/fabricated to a specific individual that cannot be used by any other person)
Wheelchairs, Electric

Prospective Reimbursement Plan for HIV Nursing Facility Services

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (Department), Division of Medical Services (Division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for HIV nursing facilities, operated exclusively for persons with human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS). Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the Division as described in this regulation. Any reimbursement rate determined, by the Division, that has been appealed in a timely manner shall not be final until there is a final decision. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement regulation shall apply only to HIV nursing facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this regulation shall apply only to services for HIV residents provided on or after December 1, 1995.

(C) The effective date of this regulation shall be December 1, 1995.

(D) The Medicaid Program shall provide reimbursement for HIV nursing facility services based solely on the individual Medicaid eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan. Where third party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The average private pay charge;

2. The Medicare (Title XVIII) rate, if applicable; or

3. The reimbursement rate as determined in accordance with sections (11), (12) and (13) of this rule.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a HIV nursing facility is found not in compliance with federal requirements for participation in the Medicaid program, Sections 1919 (b), (c) and (d) of the Social Security Act (42 USC 1396r), it may be terminated from the Medicaid program or it may have imposed upon it an alternative remedy, pursuant to Section 1919 (h) of the Social Security Act (42 USC 1396r). In accordance with Section 1919 (h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the HIV nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the Division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the Division shall recover from the entity identified in the current Medicaid participation agreement, liabilities, sanctions and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid program at any time that results in increased capital costs for the successor owner, management or leaseholder shall not be recognized for purposes of reimbursement.

(K) A facility with certified and non-certified beds shall allocate allowable costs related to the provision of HIV nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state regulation, be placed on a recipient's right to select providers of his/her own choice.

(N) The average Medicaid reimbursement rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment or recoupment or both.

(O) The reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as, but not limited to, food, laundry supplies, housekeeping supplies, linens, medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a HIV nursing facility.

(R) All illustrations and examples provided throughout this regulation are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the Department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by HIV nursing facilities during the course of one year. The submission of the budget item by the Department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components.

(4) Definitions.

(A) Additional Beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 111-131, 133-149, 151-158.

(C) Age of Beds. The age is determined by subtracting the initial licensing year from 1995 or the current year, if later.

(D) Allowable Cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this regulation. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this regulation, the Medicare Provider Reimbursement Manual (HIM-15) and GAAP. Criteria and principles will be applied using this regulation as the first source, the Medicare Provider Reimbursement Manual (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (3-95) : lines 71-89, 91-100.

(F) Asset Value. The asset value is $32,723 and is used in calculating the Fair Rental Value System.